Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: April 26, 2023	
Inspection Number: 2023-1476-0004	
Inspection Type: Complaint	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village at University Gates, Waterloo	
Lead Inspector Sharon Perry (155)	**Inspector Digital Signature** Sharon M Perry Digitally signed by Sharon M Perry Date: 2023.04.26 16:09:48 -04'00'
Additional Inspector(s) Kailee Van De Vegte (000734)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 8-10, 13-16, 2023 and offsite on March 21, 22 and 27, 2023.

The following intake(s) were inspected:

- Intake: #00018757 – a complaint regarding the care of a resident.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Staffing, Training and Care Standards

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Prevention of Abuse and Neglect

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee failed to comply with s. 24 (1) of FLTCA, 2021.

The licensee shall:
a) Ensure that residents who eat in their room on the Neighbourhood are provided the level of assistance required as outlined in their plan of care.

b) Review the Tray Service policy to determine:
- i) when trays will be delivered to residents on tray service,
- ii) how those residents eating in their rooms will be monitored and supervised, and
- iii) who will be responsible to provide the monitoring and supervision.

c) Complete an audit of residents on the Neighbourhood that are eating meals in their rooms on a regular basis to ensure it is included in their plan of care.

d) Complete an audit of residents on the Neighbourhood that eat supper meals in their room. The audit will include the residents name, assistance needed as per their plan of care, when was the meal delivered, what was the meal, was the assistance provided as per plan of care, who provided the assistance, and who provided the monitoring and supervision during the meal. The audit will include the date, the person completing the audit, if there were any deficiencies and what actions were taken to correct the deficiencies. The audit will be completed for a minimum of seven consecutive days or until there are no deficiencies identified. The audits shall be accurate and complete and kept available in the home.

e) Ensure that every person hired by the licensee or working in the home, as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in O. Reg. 246/22 and has provided the licensee with proof of graduation issued by the education provider.

Grounds
The licensee failed to protect an identified resident from neglect by the staff.

For the purpose of this Act and Regulation, "neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rational and Summary

A resident had some identified limitations and they required set up assistance and supervision with meals.

On an identified date, the resident was provided a meal and were not provided set up assistance by the agency staff member. The home was of the belief that the agency staff was a Personal Support Worker (PSW), but it was later found that they did not have PSW qualifications.

A family member visiting their loved one heard the resident yelling, went in to check on the resident, offered them some assistance and returned to the room where their loved one resided.

The family member heard the resident yelling again so went and told the Registered Practical Nurse (RPN). There was no staff supervising the resident during the meal.

The RPN went to see the resident and they called other registered staff to respond to an emergency.

Despite emergency measures the resident passed away.

The pattern of inaction and failure to provide appropriate care to the resident jeopardized the health and safety of the resident. This inaction included lack of set up assistance and supervision of the resident during the meal. In addition, the staff member assigned to provide the required care did not have the qualifications assumed by the home and was not familiar with the resident and their care needs. These inactions lead to the resident calling for help and a delay in the provision of treatment.

Sources: Resident's clinical records, interview with family member, PSWs, RPNs, Director of Nursing Care, Assistant General Manager (AGM), Operations Manager Apollo Healthcare Services, Tray Service Policy, Critical Incident Report, the home's investigation notes, and email from AGM. [155]

This order must be complied with by June 2, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.